

# The Importance of Empathy in the Patient-Clinician Relationship

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Empathy in the patient-clinician relationship is among the most powerful factors in the medical profession. Caring relationships are important not only on humanitarian grounds, but a lack of empathy has been found to have significant economic consequences as well. Breakdowns in communication between patients and physicians and patient dissatisfaction are key factors in more than 80% of malpractice claims, far exceeding medical negligence and quality of care as reasons leading patients to pursue litigation (Levenson 1994). Empathic failures include subtle non-verbal communications, such as a dominant, disrespectful, or dismissive tone of voice, which have been shown to predict the likelihood of a malpractice claim being filed with extraordinary accuracy. Psychotherapy and neuroimaging research over the last few decades have generated important insights into the mechanism of empathic relatedness that offer hope for new training modules for enhancing empathy in relationships and medical outcomes.

Studies demonstrate that different types of psychotherapy produce fairly comparable therapeutic results, despite different theoretical frameworks and approaches to treatment. Empathy is well known to be an important independent variable in outcomes. In a review of the relationship of empathy to outcomes in psychodynamic psychotherapy from the therapist perspective, 54% of 115 studies reviewed relating empathy to therapeutic outcome showed a positive relationship. This increases to 72% when empathy is considered from the patient perspective. Moreover, in a recent study examining cognitive-behavioral therapy (Burns and Nolen-Hoeksema, 1992), therapist empathy predicted clinical improvement even when controlling for other variables such as therapist experience, patient income, medication use, patient age, gender, and education. The authors found a strong relationship between patient perception of therapist empathy

and reductions in depressive symptoms. Patients who dropped out of the study had poorer outcomes and perceived their therapist as less empathic than those who completed treatment. This finding is consistent with a critical review of negative outcomes in psychotherapy research that found that lack of empathy was the best predictor of negative outcome (Mohr, 1995). These two findings support empathy as a necessary component for psychotherapy treatment success.

The MGH Psychotherapy Research Program uses observed psychotherapy process measures (e.g., psychotherapy Q-sort, PQS) and novel uses of psychophysiology (e.g., skin conductance and heart rate variability) to attempt to shed further light on the impact of empathy on clinical outcomes. Despite specific distinguishable differences in therapist interventions and activity level in interpersonal therapy (IPT) and CBT, research using the PQS observer ratings shows that there are also important similarities in IPT and CBT therapists' use of empathic variables such as offering reassurance, support, and counsel (Ablon, 1988). Thus, the overlap in these therapies may be the result of such similarities, and may help explain the lack of differential outcomes frequently observed in trials of psychotherapy types (Ablon, 2004).

In addition to observer ratings like the PQS, research has shown a pronounced psychophysiology and neurobiology to empathy. Early studies suggested that patients and therapists were highly reactive to each other producing physiologic responses that often varied together in "concordance" in some moments and oppositely in "discordance" during other moments throughout a psychotherapy session (Coleman, Greenblatt et al, 1956). This research showed a relationship between concurrent skin conductance fluctuations

(as a representation of autonomic activity) and perceived empathy in dyadic interactions (Glucksman, 1981), a finding that was recently replicated at MGH (Marci & Riess, 2005).

Importantly, there is significant overlap between brain structures that control skin conductance fluctuations and structures implicated in empathy. A recent neuroimaging study demonstrated that females watching their significant other receive a shock activated the emotional component of a well-defined “pain matrix” even though the observers themselves did not receive a shock (Singer, 2004). The authors also reported a direct correlation between activity in the observers’ anterior cingulate cortex and self-reported level of empathic sensitivity. The anterior cingulate is known to play a role in skin conductance fluctuations, and these results support concordant activation of neurobiologically relevant areas of the brain during empathic moments (Critchley, 2003).

To become effective communicators of compassion and understanding, physicians must develop and maintain empathic skills. Currently, the amounts of medical information physicians need to review with their patients, the introduction of new technologies, multiple medication choices, and the pressures of managed care have all increased to an overwhelming degree. Together, these factors have generated an urgent need to optimize the limited time clinicians have with their patients. While many physicians begin their training with humanistic ideals, empathy is known to decrease by the end of the internship year, giving way to depression, anger, and fatigue (Bellini, Baime et al, 2002). In response, medical educators are calling for more emphasis on teaching the vital skills of empathy and communication with patients. Understanding the mechanism of psychotherapy and the role of empathy in it has the potential to illuminate and enhance this critical component of the patient-clinician relationship.

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If you just learn a single trick, Scout, you'll get along a lot better with all kinds of folks. You never really understand a person until you consider things from his point of view . . . until you climb inside of his skin and walk around in it.

Atticus Finch to his daughter  
In Harper Lee's  
*To Kill a Mockingbird*

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